Suggested Draft Language for Patient Revocation of Authorization

Date:

P.I Name
P.I. Address

Title of Study:

Dear [Name of P.I.]:

I want to end my participation in the research study mentioned above.

I understand the research doctor and his/her team will continue using my protected health information already collected, but will only use the health information as it was expressed in the Consent Form I signed when I agreed to be a subject in the research study.

In addition to ending my participation, I would like to (choose one of the following):

Revoke My Authorization:

☐ I will not participate in the study. The research team will not collect any more information about me. I understand that in some cases the research team may need to use my information, even after I have revoked my Authorization, such as letting me know about safety concerns.

Continue My Authorization:

☐ I will not participate in the study, but the research team may continue to collect information from my medical record, as necessary and as discussed in the consent form I signed.

I understand that the Principal Investigator will respond to this letter.

_____ _____
Signature of Study Participant Date